Missouri. General Assembly of State of Missouri. Committee on Legislative Research.
Mentally Ill

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1. Provide a legislative library and reference service.
2. Provide a research service for members of the legislature.
3. Provide a bill drafting service for members of the legislature.

This report, which is one of several on which the Research Staff of the Committee is at work, is intended to be a factual source of information with regard to a problem which may be placed before the General Assembly in the near future.

This report does not contain recommendations.

The Committee will cause similar research studies of legislative problems to be made upon the written request of any member of the General Assembly, to the extent that the size of its research staff permits.

All publications of the Committee are available to any citizen of Missouri interested in the particular subjects considered.

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I. INTRODUCTION

Acting on the request of the Sixty-fourth General Assembly the Committee on Legislative Research made a survey of the Missouri mental hospitals in 1948. This study was published as Committee Report Number 8 under the title *The Mentally Ill: Their Care and Treatment in Missouri.* Upon receiving a draft of this first report, the committee, of its own motion, authorized a supplemental study of the mental institutions in four other selected states. The states chosen were Massachusetts, New Jersey, Oklahoma and Wisconsin.

This report is the result of the personal investigations made in these states by two members of the staff of the committee. The study has for its purpose the acquisition of first-hand information on practical purocedures, both legislative and administrative, that might be of use and value in correcting some of the situations discovered in Missouri. It confines itself to the four principal and almost universal problems found in connection with the care and treatment of the mentally ill: (1) personnel, (2) the senile patient, (3) treatment programs, and (4) methods of admission to mental hospitals.

The administrative system for the care of the mentally ill differs in each of the four states visited. In Massachusetts the Department of Mental Health has the responsibility for thirteen state hospitals with a total population of 24,000. The state hospitals operated on a $15,000,000 budget in the fiscal year ended in June 1948. The average daily expenditure in the state hospitals was $1.89 per patient.

In New Jersey the mentally ill are cared for in both state and county institutions. Three large state hospitals have a population of 12,000. Six county hospitals have 6,000 patients. The state hospitals offer active treatment and custodial care. Most of the county hospitals provide custodial care only, although two have small treatment units. The three state hospitals come under the authority of the Department of Institutions and Agencies, which controls all state institutions. The budget for the three state hospitals was $8,900,000 in the past fiscal year. New Jersey spends an average of $2.24 per day on each patient in these hospitals.

In 1946 an Oklahoma newspaper made a study which attracted widespread public attention to conditions in the state mental hospitals. The pressure of public opinion brought about the enactment in 1947 of a new mental health law and the appropriation of additional money for new buildings and for hospital operation. This law vested responsibility for the operation of the four state mental hospitals, with a resident population of 7,500, in a new Division of Mental Hygiene. In the fiscal year ended

in June 1948, the hospitals operated on a $3,400,000 budget. The per capita cost of institutional care in that year was $1.31 per day.

It must be recognized that in Oklahoma the new mental health law, the new administrative organization and the increased appropriations are events of too recent occurrence to permit significant changes in the state mental hospitals to be apparent.

Under a unique plan in Wisconsin, the great majority of mental patients are cared for in county hospitals. There are 11,500 patients in thirty-five county hospitals and 2,000 in three state hospitals. Thirty-four of the county hospitals provide simple custodial care only. The hospital in Milwaukee county, however, offers active treatment as well. The state hospitals are designed to give active treatment only, but in practice nearly one-third of their patients are custodial. The Division of Mental Hygiene has authority over the three state hospitals. The division likewise has the power to inspect county hospitals, but has no actual administrative control over them. A budget of $1,950,000 was available for the three state hospitals in the fiscal year ending in June 1948. The average daily expenditure per patient in these hospitals was $2.86. In thirty-four of the county hospitals this expenditure amounted to $.93 and in the Milwaukee County Hospital it was $2.30.

In Missouri the Division of Mental Diseases is responsible for the operation of the state hospitals for the mentally ill. This division is a part of the Department of Public Health and Welfare. Prior to July 18, 1948, Missouri had four state hospitals housing a total of 9,000 patients. On that date the state assumed control of the St. Louis City Sanitarium and its 3,400 patients. The four original state hospitals operated on a $3,980,000 budget in the fiscal year ending in June 1948. The daily expenditure amounted to $1.22 in that year. Any references made in this report to the Missouri state hospitals will apply to the four original hospitals only.

II. PERSONNEL

Staff-Patient Ratios

The first problem relating to personnel is universally the problem of determining what is an adequately staffed mental hospital. In studying this question it is not enough to discover merely the number of persons employed. This alone is not too significant. The quantity of personnel must be examined in relation to the number of patients. A relation can be established by dividing, for example, the number of patients by the number of physicians. The resulting figure is a ratio showing the average number of patients each physician cares for. The ratio is purely a statistical measure and does not depict actual working conditions.

By this measure, there is an average of 155 patients for each physician employed in the state hospitals in Massachusetts and Wisconsin (Table 1). In New Jersey there are 159 patients per physician and in Oklahoma there are 416. The ratio in Missouri is 528 patients per physician.

In the Massachusetts state hospitals there is an average of 63 patients for each nurse (Table 1). There are 75 patients per nurse in Wisconsin and 76 per nurse in New Jersey. In Missouri the patient-nurse ratio is 598 to one and in Oklahoma it is 832 to one.

In the mental hospitals in most states, the total number of attendants employed is divided among three eight-hour shifts. To determine the number of attendants working at any one time it is necessary to divide the total employed by the number of shifts. Relating this figure to the total number of patients produces a ratio more nearly approaching working conditions. By this measure, there are 21 patients per attendant in the Wisconsin state hospitals (Table 1). In Massauchusetts there are 24 patients to the attendant, in Missouri 27, in New Jersey 30 and in Oklahoma 32.

Physicians, nurses and attendants are the basic personnel of all hospitals, but the complement of a well staffed hospital operating a competent active treatment program should include, among others, psychologists, social service workers and occupational and recreational therapists. Unfortunately in some of these classifications the question is too often not merely how many there are on the hospital staff but whether or not there are any employed at all.

Some state hospitals in Massachusetts employ two or three psychologists. Other hospitals have one. In New Jersey, one or two psychologists to the hospital is the general rule. In Wisconsin each of two state hospitals employs a psychologist. There is one psychologist at one hospital only in both Oklahoma and Missouri.

Social service staffs are comparatively large in New Jersey and Massachusetts. There is an average of 367 patients per social service worker in New Jersey state hospitals (Table 1). In Massachusetts the ratio is 512 to one. One Wisconsin state hospital employs two social service workers. Another employs one. Each of two hospitals in Oklahoma has one social service worker. Only one is employed in the Missouri state hospitals.

Occupational therapists are employed in the mental hospitals in the states visited. In New Jersey there are 356 patients for each occupational therapist (Table 1). The ratio of patients to therapists is 404 to one in Wisconsin and 414 to one in Massachusetts. There are 1,248 patients per occupational therapist in Oklahoma. Missouri employs none.

Seven recreational therapists are divided among the three New Jersey state hospitals. There is one recreational therapist at each of two hospitals in both Oklahoma and Wisconsin. One Missouri state hospital has a recreational therapist. In Massachusetts recreational therapy is handled by occupational therapists.

TABLE 1

AVERAGE NUMBER OF PATIENTS PER STAFF MEMBER IN STATE MENTAL HOSPITALS

MISSOURI, MASSACHUSETTS, NEW JERSEY, OKLAHOMA, WISCONSIN

1948

Position	Missouri	Massachusetts	New Jersey	Oklahoma	Wisconsin
Physician	528	155	159	416	155
Nurse	598	63	76	832	75
Attendant[a]	27	24	30	32	21
Psychologist	[b]	1080	2420	[b]	1009
Social service worker	[b]	512	367	3743	673
Occupational therapist	[c]	414	356	1248	404
Recreational therapist	[b]	[c]	1728	3743	1009

[a]Figures for attendants adjusted to show patients per attendant on one shift.
[b]One employed at one hospital.
[c]None employed.

Source: Compiled by the staff of the Committee on Legislative Research.

Thus it is evident that in the four states visited the hospital staffs are considerably larger than those in Missouri. This does not mean that these states were satisfied with the size of their staffs. No hospital was found that was completely staffed. In Massachusetts and New Jersey quotas have been set for each position in the hospitals. These quotas do not represent the size of staff considered necessary by the American Psychiatric Association. The quotas are a compromise between the desires of hospital administrators and the dictates of state budget and personnel officials. By these standards the New Jersey state hospitals are 19 per cent understaffed in all positions. Those in Masachusetts are 25 per cent short of meeting the quotas. The staff shortage of physicians alone is 15 per cent in New Jersey and 25 per cent in Massachusetts. In New Jersey 47 per cent of the positions established for nurses are vacant; the attendant shortage is 14 per cent. In Massachusetts positions for attendants and nurses together are 31 per cent short of the quotas set. The state hospitals in Oklahoma and Wisconsin are also understaffed. Since quotas have not been established in these states, it is not possible to measure the per cent of staff vacancies. No quotas have been set in Missouri. The only standards available are the minimum staff requirements as specified by the superintendents of four state hospitals. By these standards, the four hospitals are 23 per cent understaffed in all positions. The physician shortage is 42 per cent of the need. Nurse vacancies attain 64 per cent and the number of attendants is 18 per cent short of requirements. It must be pointed out that the quotas established for personnel in Massachusetts and New Jersey are considerably higher than the minimum needs expressed by the four Missouri superintendents.

Classifications not found in Missouri

In addition to the superintendent, two other physicians occupy key administrative positions in state hospitals in Massachusetts and New Jersey. The positions of assistant superintendent and clinical director are filled in each hospital by qualified psychiatrists. The assistant superintendent handles details of admission, discharge and personnel, leaving the superintendent free to direct the overall operation of the hospital. The clinical director supervises the treatment of all patients and directs the training of physicians. He conducts all staff conferences, reviews all patients' cases, consults with and advises staff physicians and organizes lectures and discussion groups. He is a man outstanding for his knowledge of psychiatry and for his teaching ability. These two administrative physicians contribute materially to the effeciency of operation and the effectiveness of treatment in the Massachusetts and New Jersey state hospitals.

Training programs

Training programs for all types of hospital personnel were found in most of the states visited. The training of personnel is looked upon as an important way to build and maintain hospital staffs. These programs are seen as valuable means not only to attract new personnel to state hospitals but also to improve the qualifications of the present staff members.

The training of physicians in Massachusetts takes the form of teaching psychiatry to young resident doctors. Before a physician can be examined by the American Board of Psychiatry and Neurology for certification as a qualified psychiatrist, he must have three years training and experience in psychiatry. The Massachusetts state hospitals are approved by the Board to offer this training for one, two or three years. Many doctors in Massachusetts take advantage of this program for one or two years in state hospitals to learn the treatment of severe mental diseases and they generally round out their training in a mental hygiene clinic dealing with the milder forms of mental illness. This hospital training consists mainly of the supervision the young doctors receive in the treatment of patients. The clinical director and other staff physicians guide and advise them. They attend staff conferences and take part in the diagnosis of patient illnesses. They attend seminars, discussion groups, journal clubs and lectures. The training programs for physicians have gained wide recognition in Massachusetts and the applications for placement as resident physicians exceed the number of positions available. The turnover of resident physicians is indeed high in these state hospitals but what the residents add in youth and interest seems to compensate for the shortness of their stay.

There are no resident physicians in training in New Jersey state hospitals. Since there are no medical schools in the state, there is no supply of young doctors seeking training in psychiatry. The permanent staffs, however, do include many young physicians and these are in a very real sense in training. They are learning institutional psychiatry by practicing under the guidance and supervision of clinical directors and other physicians. They are given the opportunity to work with each type of therapy. After spending time on an electric shock service, for example, they move to a unit giving insulin therapy. While they are members of the permanent staffs, these physicians are actually in training for a career of state hospital service.

Only the large Milwaukee county hospital trains physicians in Wisconsin. This hospital is approved to offer three years instruction. There are several resident physicians in training. None of the Oklahoma state hospitals trains physicians. One Missouri state hospital has a resident physician receiving training.

Training programs for nurses were found in Massachusetts, New Jersey and Wisconsin. In these states a three months course in a psychiatric

hospital is required of all registered nurses. Schools of nursing have affiliated themselves with state hospitals for the purpose of offering this instruction. Every three months the schools send a new class of student nurses to the state hospitals. The classes are taught by nursing instructors and staff physicians give lectures. The students work on each type of ward under the close supervision of staff nurses. If it had nothing else to recommend it, this program would be of value to the hospitals in that some of the student nurses develop an interest in psychiatric nursing. There are always some who return to the hospitals for further training and service, and hospitals offering this affiliate training seem to have more nurses than those that do not. No nurses are trained in state hospitals in Oklahoma and Missouri.

Attendants are trained in Massachusetts, New Jersey and Wisconsin. New Jersey has developed a training program that has almost lifted the position of attendant to one of professional career status. The position of "psychiatric technician" has been created and a one-year course of training has been designed to teach qualified persons the proper psychiatric care of mental patients. The psychiatric technicians are trained for a form of work that lies midway between that performed by the registered nurse and the average attendant. Only those who are high school graduates or who have passed a special examination may enter the training course. Applicants are carefully screened by interviews. It is significant that most trainees are young men and women who have recently graduated from high schools. Some are former attendants.

The program is one-third classroom work, one-third supervised study and one-third actual practice on the ward under supervision. For the purpose of teaching and directing this course, each of the New Jersey state hospitals employs a special instructor having a master's degree in nursing education. Those who complete the one-year program receive a special certificate. All graduates enter service in New Jersey state hospitals. None go to other states. New Jersey offers psychiatric technicians the recognition, salary, employee benefits and housing that correspond to a career position. The salary range for psychiatric technicians is from $2,160 to $2,760 per year in contrast to the range of $1,560 to $1,800 for attendants. Psychiatric teachnicians are given more responsibility. They take a larger part in therapy. They take professional pride in their work. By training these skilled workers and putting them on wards in place of attendants, New Jersey is gradually improving the ward care of patients in its state hospitals.

Two Wisconsin state hospitals train attendants. A six-weeks course is under the direction of a specially trained nursing instructor. Staff nurses and physicians help in the teaching and demonstrations. Part of the training is classroom work and part is supervised work on wards.

Attendant training is in a formative stage in Massachusetts. The Department of Mental Health has recently developed an 18-month course con-

sisting of academic training and on-the-job service. Attendants spend several months in each type of hospital work. This course is being taught at one hospital, will soon be started at another and will eventually be placed in all thirteen state hospitals. There is no attendant training in Oklahoma or Missouri.

The training of other professional personnel in state hospitals takes a form resembling apprenticeship. In Massachusetts, New Jersey and Wisconsin, students from college courses in occupational therapy work at the state hospitals learning actual practices. There are students of social service in the corresponding departments in state hospitals in Massachusetts and New Jersey. The psychology departments in some Massachusetts hospitals have students working as trainees.

In Wisconsin leaves of absence for study are granted state hospital personnel. The state Division of Mental Hygiene has sent various professional workers to college for a year of special training. This training is made possible by the stipends paid the trainees by the federal government under the provisions of the National Mental Health Act. One of the purposes of this act is to help states train personnel for state hospitals. Wisconsin has made use of this law by sending a physician to Columbia University to study psychiatry, a psychiatric nurse to Washington, D. C., for special training, a psychiatric social worker to the University of Chicago and a clinical psychologist to the University of Wisconsin. The nurse is receiving instruction which will qualify her to direct the training of other nurses and attendants. Massachusetts and New Jersey have also made use of federal grants for the training of personnel.

The results being obtained in these states makes it clear that these projects are instrumental in attracting personnel to state hospitals. Yet it is apparent that the success of the training programs depends in part upon the size of the hospital staffs. It takes personnel to train personnel, but it was pointed out that it is not possible to build an adequate staff first and then to begin training personnel. Staffs and training programs must grow together. It is the practice to start these programs on a small scale as a means to attract personnel to increase the size of the staffs.

Salaries

Salaries are an incentive for attracting personnel only if they are high in comparison with other states in the area. New Jersey salaries for state hospital personnel compare favorably with those offered by other states in the East. The salaries in Massachusetts are comparatively low. While salaries are an incentive in New Jersey they are not in Massachusetts. The Massachusetts Department of Mental Health is currently pressing for higher salaries. In comparison with other states in the Middle West area, state hospital salaries are high in Wisconsin, average in Missouri and low

in Oklahoma. Salaries provide an inducement for employment in Wisconsin state hospitals, but not in Oklahoma or Missouri.

A comparison of the salaries in different states is not too meaningful for several reasons. In the first place the classifications for different levels of employment are not identical in every state. In the second place the deduction from salaries for maintenance differs. In Wisconsin the deduction for full maintenance (three meals a day and a single room) is $300 a year. In Massachusetts and New Jersey the deduction is $360 and in Missouri it is $408. No deduction is made in Oklahoma. In that state employees receive room and board in addition to their base pay. In Table 2 the minimum and maximum annual base salaries are shown for selected hospital personnel in four states and Missouri. In each position the salaries for the lowest classification are given so that as accurate a comparison as possible can be made. It must be borne in mind, however, that a bulk of the personnel may be in a higher classification.

Salaries for state hospital personnel in Wisconsin have been increased recently by a cost-of-living bonus. Under the terms of a new law, all salaries over $110 per month have been increased by $35. A bonus of $39 has been added to the $100 starting salary for attendants.

Retirement Systems

A retirement system for state employees benefits hospital personnel in Massachusetts, New Jersey and Wisconsin. Under such a plan, the state matches the contributions of individual employees to a fund. Upon retirement or disability, the person receives payments from the fund. The retirement plan in these states is believed to be a definite inducement to those considering employment in a state hospital. Attendants especially value the future security provided by the plan.

Other means of attracting qualified personnel

Other incentives for persons to seek employment in mental hospitals were found in the states visited. In all but one of the states, employees are on an eight-hour day. In Oklahoma attendants still work twelve-hour shifts. In Wisconsin attendants' salaries are based on a forty-hour week. All attendants work forty-eight hours, however, and draw additional pay over and above the base salary for the eight additional hours. The housing provided for hospital personnel is adequate in three states. Massachusetts, New Jersey and Wisconsin have physicians' residences, nurses' homes and dormitories for attendants.

In these states, too, an attractive prospect is offered the new physician. He is assigned to acute patients in the treatment center. He is not loaded down with custodial-type patients, but is given an opportunity to practice psychiatry. Older, less-qualified doctors care for the long-term patients.

TABLE 2

RANGE OF ANNUAL SALARIES FOR STATE MENTAL HOSPITAL PERSONNEL

MISSOURI, MASSACHUSETTS, NEW JERSEY, OKLAHOMA, WISCONSIN

1948

Position[a]	Massachusetts	Missouri	New Jersey	Oklahoma	Wisconsin[b]
Superintendent	$6228 — 7872	$6900 — 8400	$7500 — 9000	$2292 — 7800	$8040 — 9420
Physician	4020 — 5124	3420 — 4320	3600 — 4500	1800 — 4800	6000 — 7080
Graduate nurse	2136 — 2724	1620 — 2220	2400 — 2760	1200 — 2640	2760 — 3300
Attendant	1380 — 1764	1500 — 2100	1560 — 1800	780 — 1320	1668 — 1980
Psychologist	2472 — 3144	2580 — 3180	2400 — 3000	792 — 3600	3240 — 3900
Psychiatric social worker	3000 — 3840	2580 — 3180	2400 — 3000	(c)	3240 — 3900
Occupational therapist	1944 — 2472	1740 — 2340	1800 — 2400	1200 — 2280	2760 — 3300

In four states deductions are made from these salaries for room and board when it is provided by the hospital. The deduction for full maintenance (a room and three meals) is $408 per year in Missouri, $360 in Massachusetts and New Jersey and $300 in Wisconsin. No deduction is made in Oklahoma.

[a]Salaries are for the lowest classification in each position.

[b]Salaries for Wisconsin include a cost of living bonus of $420 per year.

[c]No classification for this position.

Source: Compiled by the staff of the Committee on Legislative Research.

In Massachusetts, staff physicians are given the time and facilities for carrying on research projects. The opportunity for research seems to be an effective means of attracting qualified doctors.

Finally, in the realm of intangibles, there was observed a certain air of hopefulness about the state hospitals in Massachusetts, New Jersey and Wisconsin. The presence of enough personnel to apply therapies that are getting results seemed to create an atmosphere in sharp contrast to that in the average, understaffed state hospital. It is certain that this air of confidence is an incentive to persons applying for state hospital service.

III. SENILE PATIENTS

The increasing number of senile patients being admitted to state hospitals results in as many problems in other states as in Missouri. Increased senile admissions are aggravating bad conditions of overcrowding. It is no longer possible to keep all old folks on certain wards, and they are being mixed with young, treatable patients. These elderly patients, who require for the most part a simple form of custodial care, are absorbing facilities of plant and personnel that could be devoted to an attempt to help those with greater chance of recovery.

County hospitals

While none of the four states claims to have solved these problems, some of them are trying new ways of handling senile patients. The most distinctive method found was the use of county hospitals in Wisconsin. In that state thirty-five county hospitals house eighty-six per cent of all patients in public mental hospitals. The remaining patients are cared for in three state hospitals, one being for mentally ill criminals. The county hospitals provide only a simple form of custodial care. Of all the patients in these county hospitals, seventy per cent are senile. One-third of the patients in the state hospitals are senile. The main feature of this method is the care of the majority of senile patients outside the large security-type mental hospital.

The county hospitals are small. The usual population is from 100 to 250 patients. Staffs are small and non-professional. A superintendent and matron and a group of attendants make up the usual complement. A physician in general practice from a nearby town calls to care for the physically ill. There are no psychiatrists, nurses or other mental hospital personnel. No therapies are offered. If a patient's mental condition requires special attention he is sent to one of the state hospitals. The county mental hospitals in Wisconsin are actually nothing more than nursing homes for the care of mental patients. They provide an inexpensive form of custody for patients not needing the more costly treatment offered in a large mental hospital.

The theory of the Wisconsin plan is to provide simple custodial care for senile and chronic patients in small county hospitals and to concentrate on active treatment in the state hospitals. A clear-cut division does not exist in practice, however. There are many senile and chronic patients who require more than simple custody. Senile patients who are agitated, depressed or bedfast must be cared for in the state hospitals as the county hospitals are not equipped to handle them. As a result the state hospitals are burdened with a number of long-term patients. The attempt made in Wisconsin to separate the functions of active treatment and custodial care can be looked upon as one way to handle senile patients. Yet it must be realized that the situation in that state has evolved over the years and was not deliberately devised as an answer to the problems created by senile patients.[1]

There are county hospitals for mental patients in New Jersey also. Six county hospitals house one-third of the patients in public mental hospitals. They offer for the most part custodial care alone. Senile admissions were forty-two per cent of all admissions to county hospitals in the fiscal year ended in June 1948. Senile admissions to state hospitals were twenty-eight per cent. The county hospitals in New Jersey serve to reduce slightly the proportion of senile persons entering the state hospitals.

Expanded facilities

The acquisition of additional plant facilities is one method used by other states for coping with the severe overcrowding caused by the influx of senile patients. In Oklahoma a former naval air base has been given the state Division of Mental Hygiene. The Norman State Hospital now uses the barracks at this base for the care of 600 senile and chronic patients requiring only custodial care. The staff at this annex is small. There is one doctor, one nurse and a number of attendants. The Trenton State Hospital in New Jersey has a similar annex. The barracks at a wartime naval base are being used to house 700 custodial patients. The use of annexes for custodial care parallels the use of county hospitals in Wisconsin. When custodial care alone is provided, staffs can be smaller and the expenditure per patient can be reduced.

Treatment

The treatment offered the senile in most of the states visited was little more than food and shelter. Several hospitals in Massachusetts seem to be getting results with a treatment program for seniles. One hospital is making a nutritional attack by feeding seniles high-protein diets with concentrations of milk solids. Another hospital attempts to improve the eat-

[1]For a discussion of state-local financial responsibility for these patients, see page 27.

ing and sleeping habits of new senile patients. This hospital has found that good food and regular hours improve the mental condition of many elderly patients. Some Massachusetts state hospitals give electric shock therapy to agitated and depressed seniles.

Other methods of meeting the problem

A method for reducing the number of senile patients in state hospitals was found in New Jersey. The hospitals refer certain senile patients to the state Division of Old Age Assistance for consideration as clients. When the division finds that a patient is qualified to receive old age assistance, the social service department at the state hospital contacts his family. Many families will accept the responsibility for the patient's care if he receives old age assistance. In this way New Jersey has been able to get a number of senile patients out of the state hospitals. More placements in homes of relatives have been made in rural than in urban areas.

No state has found a completely satisfactory solution for the problem of the senile patient. Yet various ideas for handling them were encountered in the states visited. In Massachusetts the commissioner of mental health believes that the senile are primarily a welfare problem. He reasons that the great majority do not require the type of special treatment a mental hospital offers. Therefore he feels that the senile should be cared for in public nursing homes under departments of welfare. The clinical director of a Massachusetts state hospital thought that much could be done to keep senile persons out of state hospitals by educating the public in the mental hygiene of growing old.

In New Jersey the idea was expressed that with expanded social service departments the hospitals could arrange many more home placements for senile patients qualified to draw old age assistance. The need for research into the diseases of the aged was emphasized.

In Wisconsin, state officials believe that the county hospitals should have the facilities and personnel that would permit them to care for all senile and chronic patients rather than just the simple custodial cases. The administrators of state hospitals feel that they would be able to do a much better job of rehabilitation if the county hospitals would not keep sending senile and chronic patients back to them at the least sign of disturbance.

IV. CARE, TREATMENT AND PREVENTION

In most of the states studied treatment programs seemed to be aggressive and the general level of custodial care appeared to be high. Preventive mental hygiene clinics were found in each state. Larger staffs are in part an explanation, but the higher per-patient expenditures in these states cannot be overlooked.

Active treatment programs

The active treatment programs in Massachusetts, New Jersey and Wisconsin profit by hospital staffs that are large in comparison with those in Oklahoma and Missouri. In these three states there is a concentration of personnel on treatment wards. In buildings devoted to active treatment it is not unusual to find one doctor for each thirty patients. There are physicians who devote their full time to acute patients alone. Two or three nurses to the ward are the rule in treatment centers in these states. Student nurses render valuable assistance. In New Jersey the highly-trained psychiatric technicians are also placed on treatment wards. The net result of this concentration of personnel is an increased degree of individual attention for each patient.

The general plan of active treatment is similar in each state. New patients are assigned to doctors stationed in the treatment centers. Each doctor examines and treats his own patients. Doctors assigned to custodial patients do not work with new ones as in Missouri. All treatment is under the supervision of the clinical director. Staff conferences are held five times a week in Massachusetts, New Jersey and Wisconsin, and three mornings a week are devoted to conferences in Oklahoma. In Massachusetts two types of conferences are held. Shortly after admission the patient is taken before a "new case conference" to determine the immediate course of treatment. After thirty days of examination, treatment and observation the patient is presented to a "diagnostic conference" in which his illnes is analyzed, his diagnosis is settled and his future course of treatment is determined.

Of all the special therapies for the improvement of mental conditions, electric shock is the most widely used. The ease of application and the shortage of personnel, among other factors, account for its frequent use.

Insulin shock therapy is used in each state, in some more than in others. A clinical director in New Jersey said that if he had the necessary personnel he would double the amount of insulin therapy. This, he maintained, requires one nurse for every eight patients and a physician for every fifteen patients treated. The New Jersey state hospitals use a combination of insulin and electric shock therapies. In some cases the improvement brought about by insulin is not permanent. When a patient begins to "slip back," it is the practice to apply electric shock therapy. The hospitals have found that electric shock will sustain the improvement begun by insulin therapy.

The use of psychotherapy is not extensive in any of the four states. Psychiatrists have time to follow only a limited number of cases. Group psychotherapy is used in some state hospitals in Massachusetts.

Lobotomies are being performed in three of the states visited. Six of the Massachusetts state hospitals use lobotomies on some patients unim-

proved by all other forms of therapy. One New Jersey hospital has performed numerous lobotomies of different types in an attempt to find the best kind. In Wisconsin the operation is used at the three state hospitals and the Milwaukee County Hospital. A psychiatrist in the active treatment center of the Milwaukee hospital reported that one-fourth of the patients receiving the operation can be sent home, another fourth make better patients in the hospital, another fourth are not changed and the remaining fourth are made worse.

Occupational therapy receives considerable emphasis in Masssachusetts, New Jersey and Wisconsin. There are large occupational therapy staffs and numerous shops at the hospitals in these states. In New Jersey classes in craft work are held on the wards for patients not able to go to the shops.

Recreational therapy is emphasized in New Jersey and Wisconsin. There is a recreational therapist at each hospital in these states. Representative of the work being done is the group singing and dancing organized on different wards in the Trenton State Hospital in New Jersey. The recreational therapist there has a piano mounted on wheels which she takes to ward after ward to accompany spirited singing, folk dancing, marching and calisthenics.

A team concept of therapy is in use at the Trenton State Hospital. The essence of this program is the consistent handling of a patient by all personnel in accordance with his particular needs. All staff members working with a patient attend a conference in which his illness is carefully analyzed. The clinical director explains the patient to the staff and prescribes a pattern for handling him. From that point on, all staff members approach the patient with the same attitude. They may be firm with one patient and indulgent with another. They may encourage one patient and hold back another. The patient meets the same treatment whether he is in the doctor's office, on the ward or in the occupational therapy shop.

Treatment of the chronic

The treatment of chronic or long-term patients is for the most part custodial in the states visited. In some respects the care differed from that offered in Missouri. The physicians assigned to the chronic do not have excessive patient loads in Massachusetts and New Jersey. Nurses serve on some continued-care wards in these states. In Massachusetts an attempt is made to offer chronic patients the same therapies given the acute. Many long-term patients take part in occupational therapy in Massachusetts and New Jersey.

Certain hospitals in Massachusetts reduce the non-psychiatric duties of physicians caring for chronic patients. The Boston State Hospital "farms out" the annual physical examinations of all patients. The hospital pays private physicians to make the examinations at two dollars per patient. At

the Worcester State Hospital these routine examinations are made by medical students who work on a part-time basis. Furthermore, the treatment of physical ailments is assigned almost exclusively to consultant physicians. As a result of such practices, staff physicians in Massachusetts have a greater opportunity to practice psychiatry.

Chronic patients are checked closely in Massachusetts and New Jersey. Progress notes are made on each patient every six months. The checking of long-term patients is a continuous process. In New Jersey clerks keep records which enable them each day to notify doctors of those patients that are due for progress notes.

After-care clinics

In some of the states surveyed, patients continue to receive care after they have left the hospital. The supervision of patients convalescing in their homes is a function of the social service departments in state hospitals in Massachusetts, New Jersey and Wisconsin. Special clinics for this purpose are employed. In New Jersey, for example, "after-care" clinics are held once a month in towns serving different areas of the state. Patients come to the clinics on appointment and talk to social service workers. There is a similar clinic in Wisconsin.

Family care

Family care is the placement of mental patients at board in private homes. This measure is used in Massachusetts. Before the war there were 500 patients in family care. In November, 1948, there were 230 boarded with families. Rising prices have caused a reduction in the program. The state formerly paid families eight dollars per week for each patient. This fee has been raised to twelve dollars. In many parts of the state this amount is not enough to permit a family to make a little money by boarding a mental patient. The commissioner of mental health feels that the state would have to pay eighteen dollars a week in order to get 500 patients in family care again. When a patient works around the home, a proportional amount is deducted from the fee. Family care is used mainly in the rural areas of the state. Most of the patients placed at board are long-term cases. A few acute patients are boarded out as a convalescent measure. Social service workers visit family care homes once a month. A physician makes a call every three months.

In 1945, Wisconsin enacted legislation permitting a family care program to be established for mental patients. Under this law, the weekly rates for such care cannot exceed the average cost per patient in the institution from which the patient is removed. Costs are shared between county and state as if the patient were in an institution. Up to this time, however,

this law has been inoperative due to shortage of personnel which would be necessary to find and approve homes and supervise the patients. It is planned to establish this service as soon as personnel can be secured.

Prevention

The responsibility for preventive mental hygiene has been recognized by each of the four states. There are forty-four public mental hygiene clinics in Massachusetts. The Wisconsin State Board of Health has organized fourteen clinics. Each of the three New Jersey state hospitals operates a mobile clinic. There is one state-operated mental hygiene clinic in Oklahoma.

The services offered by these clinics are widely used. The Massachusetts clinics treat 20,000 persons a year. The commissioner of mental health states that the demand for clinical services exceeds the capacity of the existing clinics by 100 per cent. Approximately 4,000 persons visit the New Jersey clinics each year. In this state the public schools make extensive use of the clinical facilities. The mental hygiene clinics are established in Wisconsin by the state Board of Health on a two-year demonstration basis. After a clinic has proved its worth in a community for two years, it is taken over by a private or public agency. The clinic in Oklahoma was started by the Division of Mental Hygiene to meet a large demand for clinical services in Oklahoma City. The clinic operates in conjunction with the state university school of medicine.

The usual personnel in these mental hygiene clinics is a psychiatrist, a psychologist and several social service workers. In New Jersey clinical staffs move from town to town, each of three teams covering a certain area of the state. Clinics are held in the larger cities several times a week, and in small towns once a month. The function of the clinics is seen as being more therapeutic than diagnostic. The director of a New Jersey clinic said that most of the effort is concentrated on children. The clinics have found that in three or four interviews they can bring about an important change in an emotionally upset child. Adults require much more time; they are usually referred to private psychiatrists or mental hospitals. It is significant that each of the four states has received funds from the federal government under the National Mental Health Act, and has made use of this money for the establishment or expansion of mental hygiene clinics.

V. METHODS OF ADMISSION

Mental hospitals in the four states admit persons under procedures that are unknown in Missouri. Each of the four states provides for newer methods of admission that work to the best interests of the patient.

Voluntary admission

Voluntary admission is an arrangement made between a person desiring treatment and the superintendent of a state hospital. The person authorizes the hospital to admit him and give him whatever treatment he needs. The procedure closely parallels that for admission to a general hospital. The laws of Massachusetts, New Jersey, Oklahoma and Wisconsin all provide for voluntary admission. Missouri laws do not.

One characteristic of this method is the fact that the person applies in writing for his own admission. The Massachusetts law specifies that the person must be competent to make written application. This means that the patient cannot be so mentally sick as to be unaware of what he is doing. In contrast, the Wisconsin statutes provide that an incompetent person may be admitted on the application of a parent, spouse or legal guardian. Parents or guardians of minors may apply for voluntary admission in both Wisconsin and Oklahoma.

Of the four states, Wisconsin alone requires a medical certificate to accompany the voluntary application. In that state a physician must examine the person and certify that he needs treatment in a mental hospital.

Another characteristic of voluntary admission is the provision that the patient may leave the hospital at his own discretion, but he must first file a written notice of his intent to leave. A period of from three to fifteen days must then elapse before his departure. The purpose of this requirement is to give the hospital time to obtain authorization to detain the patient if he requires further treatment. The fact that a voluntary patient can file notice of intent to leave at any time is a drawback to the method. Sometimes patients enter the hospital one day and give notice of intent to leave the next day. In such cases voluntary patients do not help either themselves or the hospital. In Oklahoma this difficulty is overcome by a provision requiring that voluntary patients spend sixty days in the hospital before they can leave of their own accord. The hospital can discharge the patient in less than sixty days if it sees fit. This period is considered long enough to give the hospital a chance to improve the patient by treatment.

Voluntary admission is used to varying degrees in the four states. In New Jersey and Wisconsin approximately one-fifth of all admissions to state hospitals are voluntary. The procedure is used only occasionally in Oklahoma. An overall mental health law was enacted in that state in 1947. The new methods of admission provided for in the law have not yet gained wide usage. In Massachusetts the voluntary procedure is seldom used for original admissions. Only persons having the mild form of mental illness known as neurosis can meet the conditions established by law and departmental rules. Very few neurotics submit themselves for mental hospital treatment. They usually go to clinics or private psychiatrists. The voluntary method is used in Massachusetts to a considerable extent as a supplement to another

form of admission. Quite often patients admitted for the thirty-day observational period are not ready to go home at the end of this time. Those who have improved but need further convalescence often sign voluntary papers and stay in the hospital until they are completely adjusted.

Emergency admission

Under an emergency admission a person is conveyed directly to a state hospital because his mental condition demands immediate attention. There are provisions for emergency admission in each of the four states visited.

The authorization for an emergency admission is made by various officials in the four states. In New Jersey and Oklahoma two physicians must certify in writing that the person needs immediate hospital treatment. A physician, sheriff or police officer may authorize an emergency admission in Massachusetts. There are two procedures for emergency admission in New Jersey. One requires only the certification of two physicians. The other requires a judge's authorization in addition. A judge's order is always necessary for such admissions in Wisconsin. Missouri has no such emergency admission procedure.

Emergency admissions are authorized for limited periods only. A ten-day period is specified in Massachusetts, Oklahoma and Wisconsin. New Jersey statutes provide for a twenty-day period.

Before the end of the emergency period the hospital staff must come to a decision as to the needs of the patient and arrange for his further treatment if necessary. Hospital officials in Massachusetts are of the opinion that the ten-day period is not long enough to permit the hospital to arrive at a clear understanding of the patient. They reason that a longer time, such as the thirty-day emergency period in Connecticut, is necessary in order to observe the patient and to determine his needs accurately.

The emergency procedure for admission is widely used in Massachusetts. The method is simple and physicians use it because no knowledge of legal procedure is required, but it seems that the method is also being used for cases where the actual emergency involved is subject to question. In New Jersey most patients are admitted under the emergency procedure authorized by a judge. Approximately twenty per cent of all admissions follow the emergency method not requiring a judge's certification. From five to ten per cent of the admissions in Wisconsin are emergencies. In Oklahoma the emergency procedure is used only occasionally because the law is new.

Observational admission

Observational admission is the certification that a person may be admitted to a hospital for the purpose of determining his mental condition.

This method of admission is provided for in Massachusetts, Oklahoma and Wisconsin, but not in Missouri.

Physicians and judges certify observational admissions. In Oklahoma either two physicians or a judge can make the authorization. In Massachusetts and Wisconsin a judge, acting on the findings of two physicians, may certify such admissions.

Observational admissions are authorized for a specified period. In Massachusetts the period is thirty days with ten additional days in which to make arrangements for further treatment. The Oklahoma law specifies not over sixty days. The observational period is thirty days in Wisconsin; however, a hospital superintendent may apply for extensions to a maximum of ninety days.

Various hospital administrators in Massachusetts expressed the belief that the thirty-day period was too short. While it is long enough to permit complete analysis of the patient, it does not allow enough time for the convalesence of those patients who have been helped by treatment. The sixty- or ninety-day period has the advantage that many patients can receive complete treatment under one admission. In Massachusetts many observational patients must be admitted under another procedure at the end of thirty days.

Next to emergency admissions the observational procedure is the most used in Massachusetts. Urban areas tend to use the emergency method and rural areas the observational one. Many patients are admitted for observational periods in Wisconsin. Judges resort to this method when they are in doubt as to a person's mental condition. The procedure is not widely employed in Oklahoma.

Court commitment

The court commitment of mental patients is the certification by a judge that a person is mentally ill and that he must be confined in a state hospital for an indefinite time. This is the oldest method of admission. Each of the four states and Missouri provide for such a method.

Court commitment is essentially the same in the four states. A judge of a county or district court may issue a commitment order. He must have the written and signed certificate of two qualified physicians who have examined the person. They must certify that the person's mental condition requires treatment in a state hospital. In Missouri only the oral testimony of one physician is required. Hearings are necessary in all these states. Juries may be summoned if requested.

The new mental health law in Oklahoma provides for court commitment as a secondary step to an observational admission. The law provides that the judge may order an observational admission as soon as he has been requested to commit a person. The law further provides that if the judge refuses to issue an order certifying an observational admission, he must

state his reasons in writing on the commitment order. The observational admission may be converted to a final commitment within the sixty-day period. The order for observational admission becomes one of final commitment on the receipt in court of a certificate written by the hospital superintendent stating that the patient needs continued care and treatment.

When a patient already in a state hospital must be committed, he need not be taken into court in the states studied. In Massachusetts, the court sends two physicians to the hospital to examine the patient. Their statement to the court suffices to indicate the need for continued treatment. In Wisconsin the commitment hearing is held at the hospital. The judge and his staff come to the hospital and hold the hearing in a conference room. The patient is brought in and examined. Doctors testify as to the patient's condition. The patient is granted the usual right to be represented by counsel.

In Massachusetts and New Jersey court commitment is only occasionally used as an original procedure for admission. Most patients enter state hospitals under the voluntary, emergency or observational methods. Only those persons who have a long history of mental illness are committed at the outset. Judges in these two states are reluctant to order final commitment without the hospital studying the patient. The courts do issue commitment orders on the advice of hospital staffs for those who have been originally admitted as voluntary, emergency or observational patients. Court commitment is used more widely in Wisconsin than in the two Eastern states. It is the prevailing method used in Oklahoma.

Financial responsibility

The financial responsibility for the cost of mental hospital care is connected with the matter of admission. It is interesting to notice, however, that in these four states financial questions take a secondary position to the business of admitting the patient. Decisions as to who shall pay and what amount shall be paid are made after the patient is in the hospital. This is not the case in Missouri.

The cost of caring for a patient in a state hospital may be borne by the state alone, by the state and a county jointly, by an individual alone or jointly by an individual and the state. Patients are maintained either by the state or by individuals in Massachusetts and Oklahoma. Counties bear no part of the expense in these states. Only those patients who have not established residence in a county are carried wholly at state expense in New Jersey and Wisconsin.

The cost of support is a joint responsibility of both the county and the state in New Jersey and Wisconsin. In New Jersey the actual weekly

cost of care for each patient is calculated every month.[2] When a person with a residence established in a county is in a state hospital, the county must pay one-half of this calculated cost. At the Trenton State Hospital, for example, the actual weekly cost was $16.38 per patient in September, 1948. Counties paid $8.19 per week for each patient they had in this hospital during September. The charge to the county is reduced proportionately if the patient or his relatives pay any part of the cost. In Wisconsin an average weekly cost per patient is established by each legislature.[3] The weekly expense was set at $6.50 in the past biennium and it is expected that it will be fixed at $9.50 in the next biennium. Counties pay the state one-half of this fixed cost for patients in state hospitals. The state in turn contributes one-half of the amount for each patient in a county hospital.

Patients or financially responsible relatives often pay for the cost of state hospital care. Ten dollars per week is the most that can be charged for paying patients in Massachusetts. Twenty dollars a week is the maximum fee in New Jersey. The actual weekly per capita cost is the upper limit on the charge to paying patients in Wisconsin. In November, 1948, this cost was $14.08 at one state hospital and $16.88 at another. In each of these three states amounts less than these maximum fees may be charged in accordance with the person's financial ability. Oklahoma is like Missouri in setting only one fixed rate for paying patients. The fee is $25 per month in Oklahoma and $50 a month in Misouri. The charge is not reduced according to ability to pay.

The ability of a person to pay for the support of a mental patient is determined in Massachusetts and Wisconsin by offices within the central department. Personnel are sent into the field to investigate the ability to pay and to establish a reasonable charge. In New Jersey the adjustor of the county court makes an investigation of the financial condition of a patient or his relatives. The judge then fixes a charge to be paid.

The collection of fees is facilitated in the four states by special provisions. The Wisconsin Division of Mental Hygiene maintains a Bureau of Deportation and Collection. This office has a staff of twenty-three. There are six field men who make on-the-spot investigations. Ability to pay is the basis of all collections. If a person can pay only one dollar a week, this amount is accepted. Before the establishment of this office, receipts totaled $50,000 a year. In the fiscal year ended in June, 1948, the office collected $1,000,000. The state is placed in a strong position by being empowered to file action against financially responsible relatives. All money collected goes into general revenue.

Massachusetts has a similar arrangement. A Division of Support and Settlement is a part of the Department of Mental Health. Every month the

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[2]Rev. Statutes New Jersey 1937, Title 30, Chap. 4, Art. 3, §§ 30:4-49 through 30:4-59.
[3]Laws Wisconsin 1946-47, p. 947, § 51.08.

division sends a representative to each state hospital. The agent investigates the financial status of all new admissions. In accordance with his findings, the division bills the relatives for the amount they are able to pay. In Oklahoma there are two collection agents operating out of the Division of Mental Hygiene. These agents make collections for the four hospitals. The money received is paid into the operating funds of the individual hospitals. A New Jersey law gives the state the power to take a lien on the property of persons who are not paying for the support of their relatives.

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These are the ways in which four states are attempting to meet some of the problems involved in the care and treatment of their mentally ill. In many respects, these methods differ from those used in Missouri. It cannot be said that in every case a procedure effective in one state will necessarily be of the same effectiveness in another. Yet this study does show that all states recognize that an aggressive legislative and administrative program is necessary if they are not to be overwhelmed by the magnitude of this problem.